Association of Financial Mutuals

The mutual sector's contribution to savings in the NHS, the Welfare State, and to employers and individuals

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Contents

Foreword

The Mutual sector's contribution to savings in the NHS and Welfare State
By Rt Hon Frank Field MP

Before the introduction of the NHS and Welfare State, if a worker wanted to protect themselves from the impact of ill-health, unemployment or old age, they invariably turned to their local friendly society. Where they wanted to ensure they could access medical care, they would turn to a hospital fund.

The vast majority of those organisations disappeared in the second half of the twentieth century, or focused on other business areas, or demutualised. The few remaining friendly societies and health cash plan providers tended to be the most successful, and those strongly affiliated to a particular trade or sector. But despite their size, they provide crucial support to many millions of people.

This report provides some valuable evidence of how small mutual organisations continue to operate effectively in the healthcare and protection sectors. They do this by seeking to complement, rather than compete with the NHS and Welfare State. They do not take work away from our public services, but help to pay for them. They actively support business in ensuring employees remain healthy and productive and, where they are unwell, they help get them back to work sooner.

With an NHS funding deficit and with people living longer, we must find radical solutions to the cost of care. I am increasingly attracted to the idea that the NHS and social care should be funded by higher national insurance contributions and run by a John Lewis-style mutual organisation.

This report shows how effectively mutuals can support public policy needs, and I urge Ministers to consider how they can better equip mutuals with the tools needed to support our care services, and to expand the valuable work they already perform.

Introduction

1. The National Health Service ("NHS") was established in 1948 as part of the welfare state first proposed in the Beveridge Report published in the early 1940s. The proposals aimed to abolish "five giants": want, squalor, ignorance, idleness and disease.

2. Before the NHS was established, most working people relied on their local society/mutual insurer to help them in times of ill-health or old age. Mutual insurers, friendly societies and not-for-profit insurers have a long history in helping people take responsibility for their income security and healthcare.

3. Today, the mutual sector provides customers with a range of products including health cash plans, private medical insurance and income protection policies.

4. Health cash plans ("HCP") and Private Medical Insurance policies ("PMI") are insurance policies that provide cover for the cost of everyday healthcare and protection against unexpected costs. An extensive range of treatments are covered including dental check-ups and treatments, eye tests and prescription glasses or (often) contact lenses, physiotherapy, repayment of fees paid towards a consultant physician or surgeon and payment for an annual health screening.

5. We estimate that the total cash payments made to holders of HCP and PMI policies by the mutual sector during 2016 was £281.9m.

6. Income protection ("IP") policies allow policyholders to protect their income in the event of being unable to work due to accident or sickness. They may be sold on a group basis, where the employer initiates the scheme and provides cover for a group of employees, or on an individual basis.

7. We estimate that the total cash payments made to holders of IP policies by the mutual sector during 2016 was £54.1m.

8. IP policies can be short term, where typically the benefits are payable until a return to work or for a maximum of 12 or 24 months (for example), or long term, where the benefits are payable until either a return to work or retirement.

9. Whilst both types of product (HCP/PMI and IP) offer direct benefits to policyholders, they are also beneficial to taxpayers, to employers and to the wider community through enabling a productive workforce.

10. The payments under HCP and PMI can represent direct savings to the NHS, both in terms of the cost of treatment where undertaken privately, and through savings attributable to rehabilitation and advanced recuperation.

11. The payments under IP policies represent a direct benefit payable to policyholders. They also serve to reduce welfare state outgo and increase welfare state income through, respectively, lower benefit payments and tax receipts higher (on group income protection policies) than would otherwise be received.

12. Research published by Zurich in 2014 and 2015 showed that then group IP market of about 2 million policies was saving UK taxpayers, employers and individuals approximately £460m per year through a combination of direct financial benefits and savings attributable to rehabilitation and advanced recuperation. More recent UK market statistics continue to show around 2 million group IP and 1 million individual IP policies, and extrapolating the Zurich data gives current estimated benefits of £660m per year, attributable to both mutuals and proprietaries (mutuals account for approximately 10% to 15% of market share).

Purpose of this report

13. This report summarises the findings of research carried out by OAC into the mutual sector's contribution to savings in the NHS and Welfare State, and to employers and individuals, through the provision of HCP, PMI and IP policies. It has been commission by the Association of Financial Mutuals ("AFM"), and is for their specific attention and use. Except with the written consent of OAC, the report and any written or oral information provided must not be relied upon by any other person.

14. The data underpinning our analysis is collected from the following sources:

- data we have available to us from our own client base
- publicly available information contained in annual statements
- information collected via a survey sent out by the AFM

15. In addition, we have drawn information from other public information sources available to us, for example:

- The Department of Health's Improving Lives: work, health and disability green paper
- Consultation responses to the above green paper (eg AFM and ILAG)
- The Response of the Income Protection Task Force to the Financial Advice Market Review
- Zurich Report: Income Protection and rehabilitation – working together, December 2015
- Zurich Report: Income Protection - working together to improve take-up; March 2014
- Data published by Swiss Re for the UK in their report "European Insurance Report 2015"
- Office of National Statistics and information from www.gov.uk

16. The rest of this report is subdivided into the following sections:

- NHS savings
- Welfare state savings
- Employer savings
- Individuals' savings
- Summary
- Appendix A: data
- Appendix B: assumptions

NHS Savings

Treatment costs

17. HCP and PMI are insurance policies that provide cover for the cost of everyday healthcare and protection against unexpected costs. An extensive range of treatments are covered including dental check-ups and treatments, eye tests and prescription glasses or (often) contact lenses, physiotherapy, repayment of fees paid towards a consultant physician or surgeon and payment for an annual health screening.

18. In 2016, mutual insurers, friendly societies and not-for-profit insurers paid claims of £281.9m in respect of healthcare treatments. A significant proportion of these claims represent direct savings to the NHS where the treatment is provided privately.

Rehabilitation and accelerated recuperation

19. HCP and PMI policies allow healthcare needs to be addressed sooner than they might otherwise be under the NHS. It is generally accepted (and various studies and reports have backed the theory) that early intervention allows individuals to recover more quickly and so reduces sickness levels in the workplace.

20. The Centre for Economics and Business Research (CEBR) published a report in 2015 "The benefits of early intervention and rehabilitation" which showed that where intervention services are in place the length of a typical absence falls by 17% (18% for mental health conditions).

21. A study by Medicash Health Benefits into the UK government's Children and Family Court Advisory and Support Service (Cafcass) after they introduced a Medicash Health Benefits health cash plan for their employees showed a 15% decrease in the number of sick days taken.

22. Analysis by Shepherds Friendly Society indicates that their 'back to work' scheme for people that claim on their income protection policy reduces the amount of time a claimant is off sick by 90 days, on average.

23. These statistics, although related to reductions in absence rather than in specific cost savings relating to treatment, are relevant when assessing the potential reduction in cost to the NHS from rehabilitation and accelerated recuperation since there will be less need for ongoing or prolonged follow-up treatment and investigations. The likelihood is that, where rehabilitation activities occur, there is a potentially significant cost saving to the NHS in the form of reduced referrals to specialist teams, fewer scans and even cases where surgery might be prevented. We conservatively estimate these savings as 50% of the cost of the initial treatment provided.

24. A report by Zurich in December 2015 "Income Protection and rehabilitation – working together" concluded that rehabilitation activities were undertaken in just over 25% of their income protection claims.

25. Assuming that, in 25% of claims paid under HCP and PMI policies, a saving of 50% of the cost of treatments provided is made from rehabilitation activities results in an additional saving to the NHS of £40.3m each year.

Welfare state savings

Replacing sickness benefits paid by the state

26. The UK benefit system is very complex and there are various types of benefits payable where individuals are unable to work due to sickness. Entitlement to, and the level of any payments can vary significantly. OAC do not have in-house expertise on the benefits payable under the welfare state and complex interactions with the state benefit system make it very difficult to assess the potential benefits of IP policies. For the purposes of this analysis we have simplified the assumptions we have made in order to reach a (hopefully) sensible conclusion.

27. If employees are too ill to work, Statutory Sick Pay ("SSP") is paid by the employers for up to 28 weeks. If an employee's sickness lasts beyond 28 weeks they may be entitled to Employment Support Allowance ("ESA") or Universal Credit. (Universal Credit will replace various benefits including income-related ESA.)

28. Self-employed individuals are not eligible for SSP and may apply for ESA or Universal Credit as soon as unable to work.

29. Universal Credit is reduced to allow for any other income receivable by claimants with the reduction depending on whether the income is "earned" or "unearned". The provision of benefits under an IP policy replaces any benefit from Universal Credit pound for pound (under the current formula).

30. Hence savings to the welfare state result from longer term income replacement (beyond 28 weeks) for the employed, and immediately for the self-employed. We need to make high level estimates of the proportion of IP claims that are paid to the employed and self-employed, and also the proportion of claims that are longer than 28 weeks.

31. Data very recently published by Liverpool Victoria suggests that only around 5% of individuals with income protection are self-employed (source: Liverpool Victoria article "Heightened risk of financial crisis for self-employed"). The Office for National Statistics recently published updated statistics on the UK labour market which showed that 15.1% of all people in work are self-employed. These stack up since group IP has by far the largest share of the income protection market and the self-employed do not have access to this. The self-employed also, despite having greater need for IP, have less ability to pay, according to the research.

32. We have assumed that the proportion of claims that are greater than 28 weeks is 25%. The rationale for this assumption is contained in Appendix B.

33. Using these key assumptions and those described in Appendix B, we have estimated the savings to the welfare state from the provision of IP by the mutual sector to be £6.0m each year.

34. Note that we have not allowed for any increase to tax or National Insurance receipts as a result of IP by the mutual sector as these are only relevant for group IP policies, of which we have assumed the proportion sold by the mutual sector is negligible.

Early return to work from rehabilitation

35. An early return to work will mean that any welfare state benefits due to absence are paid for a shorter period than would otherwise be the case. Additionally, tax and national insurance receipts will return to pre-sickness levels more quickly.

36. Assuming that the period of sickness and disability is shortened by 15% the estimated benefit savings to the welfare state are £0.8m per year. The extra income from tax and national insurance receipts we have estimated as £1.1m per year.

Employer savings

Statutory sick pay

37. Employers pay SSP for the first 28 weeks. They may also pay more than SSP and payments may be made for a longer period than the statutory minimum of (up to) 28 weeks.

38. These payments are independent of any additional income protection payments an employee may have so there is no direct cost saving to the employer in respect of such employees. However, the provision of rehabilitation services by the income protection provider has been shown to reduce the duration of an employee's period of sickness absence by approximately 15% on average.

39. Using the assumptions set out in Appendix B we have estimated that direct savings to employers from the reduction in SSP is £6.4m.

40. There are also likely to be indirect savings to employers when employees return to work more quickly, for example, the cost of overtime or temporary staff, the reduction in productivity and the cost of managing an employee's absence. This estimate is clearly a difficult one to make but conceptually it is likely to be at least the same as the direct cost the employer incurs from making SSP payments since the temporary staff will need to be reimbursed at least at a similar level but likely to be more.

41. When the additional costs of managing the absence, recruitment and reduction in productivity are allowed for, we conservatively estimate that this indirect saving will be approximately 1.5 times the direct cost saving ie an additional £9.7m per year.

Individuals' savings

Receipt of IP benefits

42. As a result of having their IP policy, individuals receive additional income protection payments over and above what they receive from their employer or the welfare state.

43. We estimate that the direct benefit to individuals is £48.1m per year. This does not allow for the premiums paid by the policyholder into their IP policy.

Savings in price compared to alternative products

44. Mutual insurers are far more likely than their proprietary counterparts to pass on cost savings to their customers. Cost savings arise when sickness absence is shortened through intervention from rehabilitation activities.

45. Assuming a 15% reduction in sickness absence resulting from rehabilitation activities, and assuming the insurer passes this cost saving directly on to its customers, we estimate that individuals benefit by around £9.5m per year.

Summary

46. The table below collates the cost savings accruing to the various parties arising from the provision of health cash plans, private medical insurance and income protection policies by the mutual sector. Figures are based on the level of income protection claims paid by the sector during 2016 (£51.4m) and inflation has not been allowed for.

	Annual Amount (£m)
NHS Savings: treatment costs	281.9
NHS Savings: rehabilitation and accelerated recuperation	40.3
Welfare state savings: replacing sickness benefits paid by the state	6.0
Welfare state savings: early return to work from rehabilitation	1.9
Employer savings: reduction in sick pay	6.4
Employer savings: reduction in other costs from early return to work	9.7
Individuals' savings: receipt of policy benefits and retaining income	48.1
Individuals' savings: saving in price compared to other products	9.5
Total	**403.8**

Conclusions

47. Clearly there is scope for a range of assumptions to be made, and potentially a wide range of possible cost savings as a result. Where possible we have tried to support the assumptions we have made from the sources available.

48. We have attempted to correlate this analysis with other published research, in particular the Zurich papers. Most of the results for IP above correlate reasonably well except for the welfare state savings for replacing sickness benefits where our figure is much lower than Zurich's would suggest. This is an area that we would like to explore further, particularly since it is a complicated area of the benefit system and there are many changes taking place at present.

49. There are further significant benefits, not covered by this research, that these products undoubtedly provide to the community at large by better enabling a healthy and productive workforce. Such benefits are impossible to cost but could easily run into millions.

50. A further consideration is the impact of Insurance Premium Tax ("IPT") in the figures above. We estimate that holders of HCP and PMI policies paid an extra £32.7m during 2016 due to IPT. If IPT were to be abolished then these policies would become more affordable and more attractive to individuals and employers alike. A 20% increase in take-up of these policies could potentially add a further £37.0m per year to the benefits shown above, even after allowing for the loss of IPT revenues to the welfare state.

51. This research, we hope, has provided evidence of how small mutual organisations continue to complement the NHS and Welfare State, and do provide quantifiable financial benefits. Of particular note is the active support these products provide to employers and individuals in ensuring employees remain healthy and productive.

52. Commentators have illustrated the considerable gap in protection benefits for the wider community. This paper sets out how mutuals support existing policyholders – the benefits will clearly be even greater with greater participation however that can manifest itself.

53. OAC, like many of its mutual clients, is committed to the AFM and the mutual sector in general. The analysis in this report highlights the contribution the sector makes, and its potential to contribute, to the country via the support it provides to the care and welfare services provided by the Government, and directly to the individuals in need of these services.

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